STATE OF MICHIGAN

IN THE SUPREME COURT

APPEAL FROM THE MICHIGAN COURT OF APPEALS
O'CONNELL, P.C., AND JANSEN AND MURRAY, JJ.

SHIRLEY HAMILTON, as Personal Representative of the Estate of **ROSALIE ACKLEY**, Deceased

Plaintiff-Appellant,

and

BLUE CROSS/BLUE SHIELD OF MICHIGAN,

Intervening Plaintiff

vs

MARK F. KULIGOWSKI, D.O.

Defendant-Appellee

Supreme Court No.: 126275

Court of Appeals No.: 244126

Saginaw County Circuit Court No.: 00-033440-NH

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PLAINTIFF-APPELLEES' BRIEF ON APPEAL

****** ORAL ARGUMENT REQUESTED******

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COUNTER STATEMENT OF QUESTIONS PRESENTED

I. **WITHIN THE MEANING OF MCL 600.2169(1)(a), DID PLAINTIFF-APPELLEE'S EXPERT DR. ARNOLD MARKOWITZ, A BOARD CERTIFIED INTERNIST, SPECIALIZE IN THE "SAME SPECIALTY" AS DEFENDANT-APPELLANT DR. MARK KULIGOWSKI, D.O. AN INTERNAL MEDICINE SPECIALIST?**

Plaintiff-Appellee's Answer.....**YES**

Defendant-Appellant's Answer.....**NO**

The Trial Court's Answer..... **YES**

The Court of Appeal's Answer.....**YES**

II. **WITHIN THE MEANING OF MCL 600.2169(1)(b)(I), DID PLAINTIFF-APPELLEE'S EXPERT DR. ARNOLD MARKOWITZ, DEVOTE A MAJORITY OF HIS PROFESSIONAL TIME TO THE ACTIVE CLINICAL PRACTICE OF INTERNAL MEDICINE?**

Plaintiff-Appellee's Answer.....**YES**

Defendant-Appellant's Answer.....**NO**

The Trial Court's Answer..... **NO**

The Court of Appeal's Answer.....**YES**

III. **WAS DR. MARKOWITZ QUALIFIED TO GIVE STANDARD OF CARE TESTIMONY WHERE DR. MARKOWITZ WAS BOARD CERTIFIED IN INTERNAL MEDICINE AND TESTIFIED THAT HE ROUTINELY TREATED PATIENT'S SUCH A ROSALIE ACKLEY?**

Plaintiff-Appellee's Answer.....**YES**

Defendant-Appellant's Answer.....**NO**

The Trial Court's Answer.....**Not Addressed as the Issue Was Not Raised Before the Trial Court**

The Court of Appeals' Answer.....**Not Addressed as the Issue Was Not Raised Before the Trial Court**

STATEMENT OF JUDGMENT APPEALED FROM AND STATEMENT OF BASIS OF JURISDICTION

Defendant-Appellant appeals from the April 22, 2004, Opinion from the Michigan Court of Appeals reversing Saginaw County Circuit Court Judge William A. Crane's orders striking the testimony of Plaintiff's expert and granting Defendant's Motion for Directed Verdict. (**Appendix, pp 96b and 111b**). This Court has jurisdiction over this appeal by leave granted. (**Appendix, p 4b).**

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STATEMENT OF FACTS

I. Factual Background

This is a medical malpractice action arising out of Defendant-Appellant, Dr. Mark F. Kuligowski's failure to appropriately diagnose and treat Plaintiff's decedent Rosalie Ackley. (**Appellant's Appendix p. 14a**). As a result of the Defendant-Appellant's negligence, Mrs. Ackley suffered a massive debilitating stroke which lead to her demise. (**Appellant's Appendix pp 15a, 16a , ¶¶ 11, 14, and 15**).

On or about August 13, 1992, Plaintiff's Decedent Rosalie Ackley began treating with Defendant-Appellant Dr. Kuligowski. (**Appellant's Appendix p. 14a, ¶ 4**). Over the next 5 ½ years, Defendant-Appellant treated Mrs. Ackley for various problems including: hypertension, diabetes, weight control, and a thyroid ailment. (**Appellant's Appendix p. 15a, ¶ 5**).

On March 19, 1998, Mrs. Ackley presented to Defendant-Appellant Dr. Kuligowski with complaints of intermittent left arm numbness and weakness over a three day period. (**Appellant's Appendix p. 15a, ¶ 6**). Mrs. Ackley provided a history to Defendant-Appellant Dr. Kuligowski of having had a history of having been diagnosed with a blockage in her neck years earlier. (**Appellant's Appendix p.15a. ¶ 7**). Dr. Kuligowski performed a physical examination on Mrs. Ackley and noted that she had bilateral carotid bruits[1]. (**Appellant's Appendix p15a, ¶ 9**). Defendant-Appellant suspected a transient ischemic attack (TIA) and bilateral carotid artery disease[2]

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[1] A Bruit is an abnormal sound of venous or arterial origin heard on auscultation. It is frequently heard in cases where blockage is present in the venous or arterial system.

[2] A transient ischemic attack (TIA) is a disturbance in brain function resulting from a temporary deficiency in the brain's blood supply. The risk of having TIA is increased if a person has high blood pressure, heart disease, and/or elevated cholesterol. There are several environmental risk factors for cerebrovascular

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and ordered bilateral carotid doppler studies and an echocardiogram at Saginaw Hospital. Dr. Kuligowski advised Mrs. Ackley and her daughter that there was no need for immediate concern. **(Appellant's Appendix p 15a , ¶ 8,9)**.

The following day, Mrs. Ackley's daughter, Shirley Hamilton, called Defendant-Appellant Dr. Kuligowski with concerns regarding her mother's symptoms and condition. Again Dr. Kuligowski advised her that there was no cause for immediate concern. **(Appellant's Appendix p. 15a , ¶ 10)**.

Defendant-Appellant Dr. Kuligowski, however, failed to recognize that in light of her symptoms and history, Mrs. Ackley was at a high risk for a stroke. As a result, he failed to take steps to immediately evaluate Mrs. Ackley's condition and/or to obtain an evaluation by a neurologist and/or neurosurgeon. **(Appellant's Appendix pp 15a-16a, ¶ 13)**.

Three days later, Mrs Ackley suffered a massive debilitating stroke caused by a complete occlusion of her right internal carotid artery which evolved to a right middle cerebral artery infarction. **(Appellant's Appendix p. 15a , ¶ 11)**. Mrs. Ackley continued to suffer from the

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disease including smoking and heavy alcohol assumption. TIA's are more common in middle aged individuals and are progressively more likely with advancing age.

A TIA starts suddenly and usually lasts 2 to 30 minutes. The symptoms manifested by a patient suffering from a TIA vary depending upon which part of the brain is deprived of blood and oxygen. Several common symptoms include: loss of or abnormal sensation in an arm or leg or one side of the body, weakness or paralysis of an arm or leg or one side of the body, dizziness, slurred speech, difficulty thinking of the appropriate word or saying it, and imbalance and falling. These symptoms are temporary and reversible leaving no permanent neurologic sequelae.

Although transient, TIA's are often recurrent and in many instances presage a stroke. Various studies have been done regarding the incidence of TIA's progressing to a stroke. The results of those studies suggest that as high as 20% progress to stroke within the first month with 3% to 9% suffering a stroke within one week. Treatment for TIA is aimed at preventing a stroke. Antiplatet therapy with aspirin and other anticoagulants should be initiated as soon as possible to reduce the incidence of a stroke. Surgical evaluation should also be obtained to determined whether the patient would benefit from an endarterctomy.

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neurologic sequelae from her stroke up to the time of her death in December, 2000. (**Appellant's Appendix p. 16a , ¶ 14**).

II. Procedural History

The estate of Mrs. Ackley brought suit in this matter alleging that Defendant-Appellant Dr. Kuligowski failed to identify Mrs. Ackley as a patient at high risk for stroke, failed to undertake a prompt work-up for the condition, and failed to get an urgent referral. (**Appellant's Appendix p.14a**). Trial in this matter began on or about April 30, 2002. (**Appendix p. 12b**). On May 3, 2002, the Plaintiff called Dr. Arnold Markowitz to testify as to the standard of care. (**Appendix p. 13b**). Dr. Markowitz identified himself to the jury as "Dr. Arnold Markowitz. I'm an internist in the Detroit Metropolitan area. I practice in Oakland County." (**Appendix p.30b, lns 18-20**). He testified that he attended medical school at Wayne State University, he did a residency in internal medicine as well as a fellowship in his sub-speciality, infectious disease. (**Appendix pp 32b-33b.**). He testified that he is licensed as a physician in the state of Michigan, and he is board certified in Internal Medicine. (**Appendix pp. 31b, 34b**) Dr. Markowitz testified that 98 % of his time is involved in the active practice of medicine. (**Appendix p. 33b**).

With respect to his practice he testified as follows:

Q. Would you explain for us what the nature of your practice there is in Keego Harbor?

A. Well, I have basically a two part kind of practice, I'm in the office half the time, and I'm at the hospital the other half of the time as a consultant. At my office I do internal medicine and infectious disease. In the hospital it's infectious disease related issues. (**Appendix pp 30b-31b**).

* * * *

Q. Okay. In your practice, in your office practice, do you take care of patients like

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Rosalie Ackley?

A. Yes, I do.

Q. Okay. Do you take care of patients that are in their 60s and 70s with high blood pressure.

A. Yes, I do.

Q. With diabetes?

A. Yes.

Q. With Obesity?

A. Yes.

Q. With high cholesterol?

A. Sounds like all my patients, yeah.

Q. That have had TIA's

A. Yes.

Q. That have had strokes?

A. Yes.

Q. How frequently do you see patients like that?

A. Well, everyday. Except when I'm on vacation basically. (**Appendix pp 34b-35b**).

He further explained that infectious disease is a part of internal medicine.

Q. Now, the subspecialty training you did is what?

A. I did a fellowship in infectious diseases. Basically what that is is we have a primary interest in issues that relate to fevers, to bacterial infections, viral infections, meningitis, postoperative infections, wound infections, and how to use antibiotics.

Q. Isn't that kind of what an internist does anyway?

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A. Well, internists have a broader area of expertise, but certainly a great deal of it relates to infection **(Appendix p 32b)**

He further testified that because Infectious disease, is a wholly contained sub-specialty of internal medicine, 100% of his professional time was involved with internal medicine patients. **(Appendix p. 100b)**.

Following the testimony of Dr. Markowitz, Defendant moved to strike Plaintiff's expert based on his assertion that Dr. Markowitz did not satisfy the requirements of **MCL 600.2169; MSA 27A.2169** as a majority of his professional time was spent in the "specialty" of infectious disease and not internal medicine. **(Appendix p. 65b)**. Defendant's argument differentiated the speciality of internal medicine from its wholly contained sub-specialty of infectious disease. Plaintiff opposed this motion. **(Appendix pp 65b-.96b)**.

The trial Court subsequently granted the Defendant's motion striking Dr. Markowitz. This was premised on the court's finding that the practice of the sub-specialty of infectious disease was not the practice of the specialty of internal medicine. **(Appendix p. 95b)**. In light of this ruling, the Defendant-Appellant moved for a Directed Verdict based on the lack of an expert to provide standard of care testimony. **(Appendix pp 102b-103b)**. The trial court granted Defendant-Appellant's motion for Directed Verdict **(Appendix p 103b)** and an order to that effect was entered on or about May 9, 2002. **(Appendix p. 111b)**.

Plaintiff-Appellee filed a Motion for New Trial on or about May 30, 2002. **(Appendix pp 113b-125b)**. Oral argument was heard on Plaintiff-Appellee's motion on or about August 13, 2002. **(Appendix p. 126b-158b)**. Following the hearing, the trial court took the matter under advisement **(Appendix p, 157)**, but ultimately issued a written opinion on or about September 10, 2002, denying

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Plaintiff-Appellee's Motion for New Trial. (**Appendix p 159b**).

Plaintiff-Appellee appealed the trial court's decision to the Michigan Court of Appeals by means of claim of right. Plaintiff-Appellee argued that the trial court's decision was premised upon the court's erroneous interpretation of **MCL 600.2169; MSA 27A.2169** and the erroneous finding that by practicing in the area of infectious disease, Dr. Markowitz was not practicing in the specialty of internal medicine.

Following oral argument, the Court of Appeals reversed the trial court's decision granting Defendants-Appellant's Motion for Directed Verdict. (**Appendix p. 1b**). The Court of Appeals strictly construed the statutory language of **MCL 600.2169(1); MSA 27A.2169(1)** as requiring experts in medical malpractice actions to match the "specialty" of the Defendant doctor. The Court of Appeals declined to graft a requirement for matching sub-specialties onto the plain language of the statute. (**Appendix p 2b.**) The Court also found that Dr. Markowitz devoted the majority of his professional time to the "active clinical" practice of Defendant's internal medicine "specialty."

The Defendant-Appellant sough application for interlocutory leave to appeal to the Michigan Supreme Court. The Defendant-Appellant argues that Plaintiff's expert was not a specialist in the same specialty as the Defendant nor did Plaintiff's expert spend a majority of his professional time in the active clinical practice of the same specialty. On July 14, 2005, Defendant's application for leave to appeal was granted. In the order granting leave this Honorable Court directed the parties to include among the issues briefed two issues:

1. The proper construction of the words "specialist" and "that specialty" in **MCL 600.2169(1)(a)** and **MCL 600.2169(1)(b)(I)**, and

2. The proper construction of "active clinical practice" and "active clinical practice of that specialty" as those terms are used in **MCL 600.2169(1)(b)(I)**. (**Appendix pp.**

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4b-5b).

ARGUMENT

I. **THE TRIAL COURT AND THE COURT OF APPEALS DID NOT ERR IN FINDING THAT PLAINTIFF-APPELLEE'S EXPERT DR. ARNOLD MARKOWITZ, A BOARD CERTIFIED INTERNIST, SPECIALIZED IN THE "SAME SPECIALTY," WITHIN THE MEANING OF MCL 600.2169(1)(A), AS DEFENDANT-APPELLANT DR. MARK KULIGOWSKI, D.O. AN INTERNAL MEDICINE SPECIALIST.**

A. **Standard of Review**

The issue currently before this court involves a question of statutory construction. Statutory construction is a question of law which is reviewed *de novo*. **Auto Owners Insurance Co. v Allied Adjusters & Appraisers, Inc., 238 Mich App 394, 396; 605 NW2d 685 (2000).**

As a general rule, the primary goal of statutory interpretation is to ascertain and give effect to the intent of the legislature. **In the Matter of The Estate of Flynn, 181 Mich App 570, 573; 450 NW2d 77 (1989).** However, when statutory language is clear and unambiguous, the legislature is presumed to have intended the meaning it plainly expressed, and the judiciary is precluded from varying the statute's plain meaning. **See Berry v City of Belleville, 178 Mich App 541, 548; 444 NW2d 222 (1989), lv den 434 Mich 909 (1990); Utter v Secretary of State, 179 Mich App 119, 122; 445 NW2d 175 (1989)** Statues are to be construed as written regardless of the result, and statutory construction and concerns about legislative intent play no role in the judicial process if the statutory language is unambiguous. **See Gilbert v Second Injury Fund, 244 Mich App 326, 328-330; 625 NW2d 116, app denied 465 Mich 876; 633 NW2d 824 (2001).** Thus, where the statute is clear judicial construction is neither required nor permitted as the statute speaks for itself. **See Osner v Boughner, 180 Mich App 248, 268; 446 NW2d 873 (1989); Joy Management Co. v**

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Detroit, 176 Mich App 722, 730; 440 NW2d 654, lv den 433 Mich 860 (1989).

If judicial construction or interpretation is necessary, the Court must give effect to the legislative intent. **Phipps v Campbell, Wyant & Cannon Foundry, Division of Textron, Inc., 39 Mich App 199, 216; 197 NW2d 297 (1972).** The Court should presume that every word is used for a purpose. **Pohutski v Citty of Allen Park, 465 Mich 675, 684; 641 NW2d 219 (2002).** "The Court may not assume that the Legislature inadvertently made use of one word or phrase in stead of another." **Robinson v Detroit, 462 Mich 439, 459; 613 NW2d 307 (2000)**. Words are to be assigned their ordinary meaning unless it appear from the context of the statute or otherwise that a different meaning was intended. **Phipps, supra at 216.** Thus, a statutory term can not be viewed in isolation, but must be construed in accordance with the surrounding statutory text and the statutory scheme. **Breighner v Michigan High School Athletic Ass'n, Inc., 471 Mich 217, 232: 683 Nw2d 648 (2004)** Additionally, "because the statutory requirements [of **MCL 600.2169; MSA 27A.2169**] constrain a plaintiff's ability to present his or her case to a jury, the requirements should be broadly interpreted." **Gawel v Schatten, 109 F. Supp.2d 719 (E.D. Mich, 2000)**.

B. Analysis

The statutory language at issue in this case at bar is the statute governing the criteria and qualifications for experts in medical malpractice action. **MCL 600.2169; MSA 27A.2169.** This statutory provision provides that:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> > (a) If the party against whom or on whose behalf the testimony is offered is **a specialist, specializes** at the time of the occurrence that is the basis for the action **in the same specialty as the party against**

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> **whom or on whose behalf the testimony is offered.** However, if the party against whom or on whose behalf the testimony is offered is **a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.**

The overall legislative intent behind the enactment of the tort reform legislation of which **MCL 600.2169; MSA 27A.2169** was a part was to deter frivolous medical malpractice claims. **Gawel, supra at 723 (citing VandenBerg v VandenBerg, 231 Mich app 497, 502; 586 NW2d 570 (1998)).** The legislative intent behind the statutory provision setting forth expert qualifications was to limit the testimony of experts perceived to be "hired guns" and to ensure that expert witnesses actually practice and/or teach medicine so that they have firsthand practical expertise in the subject matter about which they are testifying. **See Report of the Senate Select Committee on Civil Justice Reform (September 26, 1995); McDougal v Schanz, 461 Mich 15, 48 n 13; 597 NW2d 148 (1999).**

1. **The Language of MCL 600.2169(1)(a); MSA 27A.2169(1)(a) Requiring an Expert to Be A Specialist in the Same Specialty as the Physician Against Whom He is Testifying Does Not Require the Matching of Sub-Specialties.**

A. **What is the Meaning of the terms "specialty" and "specialist" as used in MCL 600.2169(1)(A); MSA 27A.2169(1)(A).**

The first sentence of **MCL 600.2169(1)(a); MSA 27A.2169(1)(a)** uses the terms "specialty" and "specialist." The terms "specialty" and "specialist" are not specifically defined by the statute. The term "specialty" is defined as "[t]he branch of medicine, surgery, dentistry, or nursing in which a specialist practices." **Taber's Encyclopedic Medical Dictionary (20th ed.)** The term "specialist" can be defined in several was. The term "specialist" can mean "a physician or other health

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professional who has advanced education and training in one clinical area of practice." **Id.** It can also be defined as "[o]ne who devotes professional attention to a particular specialty or subject area" **Decker v Flood, 248 Mich App 75, 83 n. 5; 638 NW2d 163 (2002) (citing Steadman's Medical Dictionary (26th ed.)** or as "a medical practitioner who deals only with a particular class of diseases, conditions, patients, etc." **Cox v Board of Hospital Managers of the City of Flint, 467 Mich 1, 651 NW2d 356 (2002) (citing Random House Webster's College Dictionary (1997)).**

The second sentence of **MCL 600.2169(1)(a); MSA 27A.2169(1)(a)** uses the term "board certified" to define the term "specialist." While the term "board certified" is not defined in the statute at issue, the public health code defines "board certified" as "certified to practice in a particular medical specialty by a national board recognized by the American board of medical specialties or the American osteopathic association. " **MCL 333.2701(a); MSA**

The fact that the term "specialty" refers to branches of medicine and the term "board certified" refers to certification from nationally recognized medical boards, the term specialty as utilized in **MCL 600.2169; MSA 27A.2169** refers to areas of medicine recognized and established by nationally recognized boards. Any other definition would create the circumstance where a physician could assert they were a "specialist" in a unregulated and self-designated specialty area. For example a physician who treats only women may assert that they are a "Women's Health Specialist" or a physician who works exclusively with nursing home patients may assert that they are a specialist in nursing home care.[3] Looking to the medical societies to establish what is a recognized specialty is consistent with Michigan jurisprudence. **See Watts v Canady, 253 Mich**

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[3] This argument was in fact unsuccessfully made before St. Clair County Circuit Court Judge Peter E. Deegan, by a Defendant in the matter of Barnum v Landis, Lower Court No. D 99-002417.

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App 468, 470; 655 NW2d 784(2003) and Nelson v Gray, unpublished per curiam opinion of the Court of Appeals, decided August 26, 2003 (Docket No. 236369)

B. What Specialties are Recognized by the National Medical Boars?

As the public health code indicates, there are two nationally recognized organizations that establish medical boards, the American Board of Medical Specialties and the American Osteopathic Association. **MCL 333.2701(a); MSA** . The American Board of Medical Specialties recognizes 24 medical specialty boards. (**Appendix pp 160b-162b**). The American Osteopathic Association recognizes 18 medical specialty boards. (**Appendix pp 163b-166b**). Each specialty area recognizes various sub-specialties. (**Appendix pp. 161b-166b**). The word "sub" is a prefix meaning subdivision or subordinate portion of. **See Merrim Webster Dictionary (1994).** In order to be recognized as a sub-specialist in a sub-specialty, you must first be boarded in the specialty area of which the sub-specialty is a part. **(Appendix pp 168b-170b).**

In daily usage, speakers tend to use imprecise language and shorten terminology by dropping the prefix "sub" from the phrases "sub-specialty" and "sub-specialist" and use instead only the term "specialty" or "specialist." This common use of imprecise terminology does not changed a "sub-specialty" into a "specialty" nor does it change the fact that the legislature used only the precise term "specialty" in **MCL 600.2169; MSA 27A.2169.**

C. The Legislature was Aware of the Existence of Medical Sub-Specialties and Choose Only to Require Matching of Specialties.

It is an established principal that the Legislature is presumed to know the law. **See William v Auto Club Group, Inc. Co. 224 Mich app 313; 569 NW2d 403 (1997);Consumers Power Co. v Dep't of Treasury, 235 Mich App 380, 387; 597 NW2d 274 (1999).** The Legislature is also

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presumed to be familiar with the principles of statutory construction.

Following these established principals, the Michigan Court of Appeals in **Watts** v **Canady, supra at 470** stated that:

> Perhaps the use of the word "specialty" in [MCL] 600.2169 could be better defined. But we presume the Legislature was familiar with the term "sub-specialty" when it enacted the provision, and the Legislature chose to use "specialty" not "sub-specialty." We see no grounds for imposing a sub-specialty requirement when the Legislature has spoken in terms of a specialty requirement. We note that while the line between specialty and sub-specialty may appear to be fuzzy, the terms can be defined precisely according to the standards set forth by the AMA.

Unlike the Court in **Watts**, this Honorable Court need not presume that the Legislature was aware of the existence of "sub-specialties." Existing statutes clearly establish that the Michigan Legislature was well aware of the relationship between the term "specialty" and "sub-specialty." **MCL 333.17001(1)(a)(ii)(A); MSA 14.15(a)(ii)(A)** provides that:

> (A) Was the sole sponsor or a co-sponsor, if each other co-sponsor is either a medical school approved by the board or a hospital owned by the federal government and directly operated by the United States department of veteran's affairs, of not less than 4 postgraduate education residency program approved by the board under section 1703(1) for not less than the 3 years immediately preceding the date of an application for a limited licence under section 16182(2)(c) or an application fora full licence under section 17031(2), provided that at least 1 of the residency programs in **the specialty area of medical practice, or in a specialty area that includes the sub-specialty of medical practice in which the applicant for a limited license proposed to practice or in which the applicant for a full license has practiced for the hospital.**

This statute makes it clear that the Legislature was well aware of the existence of the primary medical specialties and their sub-specialties. It also exemplifies the Legislature's understanding that specialty areas are divided into various sub-specialties. Because the Legislature is presumed to know the law, **See William, supra,** and has exemplified its understanding of medical specialties and sub-

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specialties, the use of the term "specialty" only in **MCL 600.2169; MSA 27A.2169**, demonstrates that the Legislature was requiring only that standard of care experts in medical malpractice actions match the Defendant's primary specialty area and not sub-specialties.

The Defendant-Appellant relies on the Court of Appeals decision in **Decker v Flood, 248 Mich App 75 ; 638 NW2d 163 (2001)** to support his assertion that **MCL 600.2169; MSA 27A.2169** requires standard of care experts to match the sub-specialty of the Defendant in a medical malpractice action. Defendant-Appellant reliance on that case is misplaced. In **Decker,** the Court held that a dentist who specialized in endodontics did not match the Defendant who was a general dentist who also performed root canal. **Decker**, however, did not deal with the issue of "specialist" versus "sub-specialist" but instead dealt with the distinction between a "general practitioner" and a "specialist." **MCL 600.2169;MSA 27A.2169** expressly addresses the issue of a general practitioner and expressly distinguishes them from "specialists." The statute as previously discussed, makes no such distinction between a "specialist" and "sub-specialist." While in **Decker** the Court was thus adhering to the statutory language in separating a general practitioner from a specialist, we would be violating the express statutory language in separating a specialist from a sub-specialist. Defendants-Appellant's classification of himself as a "general internist" and Plaintiff's expert as a "infectious disease" specialist, is a feeble attempt to force the facts of this case into a "general practitioner" and " specialist" scenario as was present in the **Decker** case.

Additionally, the Defendant's interpretation of the term "specialty" to include "sub-specialties" would result in "sub-specialities" being recognized as separate and distinct specialties under the statute. If this is the case, then this Court's recent decision in **Halloran v Bhan, 470 Mich 572, 683 NW2d 129 (2004)** would be incorrect. In **Halloran** the Defendant doctor was board

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certified in internal medicine with a certificate of added qualifications in critical care medicine. **Id. at 574**. Plaintiff's expert was a board certified anesthesiologist with a certificate of added qualification in critical care medicine. **Id. at 575.** The Court held that the expert's specialties did not match as the Defendant was an internal medicine specialist and the proposed expert was a anesthesiology specialist. **Id**. at 579.

If critical care was a distinct "specialty" under the statute as proposed by the Defendant's then the fact that the defendant and the expert's "specialty" was the result of certification from different specialty boards would make no difference. Specialists are held to a national standard. **MCL 600.2912a; MSA 27A.2912(1).** Thus, presumptively the same national standard would apply to a "critical care specialist" regardless of his or her certifying boards[4]. Thus, in **Halloran** the board certified anesthesiologist would have been allowed to testify against the board certified internist.

D. What is Meant by the term "same specialty"?

As discussed at length above "specialty" as used in **MCl 600.2169; MSA 27A.2169** refers to the broader primary specialty area of a health care provider as recognized by one of the nationally recognized specialty boards. The term "same" means " not different," **See Merriam Webster Dictionary (1994)**. Thus, the term "same specialty" means the identical primary specialty area.

2. Application To This Case

In the case at bar, Plaintiff's expert Dr. Markowitz was qualified to give standard of care

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4 Nothing in the **Halloran** case suggested that there was evidence that the standards training, or type of treatment rendered by a critical care specialist with a primary board certification in anesthesiology would have been different than that of critical care specialist with a primary certification in internal medicine.

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testimony pursuant to **MCL 600.2169(1)(a); MSA 27A.2169(1)(a)** The Defendant Dr. KULIGOWSKI was a board certified internist practicing in the state of Michigan. Plaintiff's expert, Dr. Markowitz is also a board certified internist practicing in Michigan. Thus, Plaintiff's expert is board certified in the same specialty area, Internal Medicine, as the Defendant. The fact that Dr. Markowitz has an interest and practice in the sub-specialty of infectious disease does not change the his status as an internal medicine specialist.

Moreover, contrary to the Defendants assertion, the fact that the Court in **Nippa v Botsford General, 251 Mich App 664; 651 NW2d 103 (2002)** stated that Dr. Markowitz specializes in infectious disease is not binding. There was no argument made in **Nippa** that infectious disease was a sub-speciality, which was not required to be matched. This issue appears to have been conceded. As such statements as to Dr. Markowitz's "speciality" in infectious disease is dicta, which is not binding precedent as the issue was not raised, argued, or decided by the Court. **See Bauer v City of Garden City, 163 Mich App.562.**

II. THE COURT OF APPEALS DID NOT ERR IN FINDING THAT PLAINTIFF-APPELLEE'S EXPERT DR. ARNOLD MARKOWITZ, DEVOTED A MAJORITY OF HIS PROFESSIONAL TIME TO THE ACTIVE CLINICAL PRACTICE OF INTERNAL MEDICINE WITHIN THE MEANING OF MCL 600.2169(1)(b)(I); MSA 27A.2169(1)(b)(I).

A. Standard of Review

Again the issue before this court involves a question of statutory construction which is reviewed de novo. **Auto Owners Insurance Co., supra** The same standard of review applies as was identified in Argument I.

B. Analysis

In addition to requiring that an expert match the same specialty as the Defendant against

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whom he is testifying, **MCL 600.2169(1)(b); MSA 27A.2169(1)(b)** provides that

> (b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a **majority of his or her professional time** to either or both of the following:
>
> (I) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, **if that party is a specialist, the active clinical practice of that specialty**.
>
> (ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.
>
> (c) If the party against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness, during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (I) Active clinical practice as a general practitioner.
>
> (ii) Instruction of students in an accredited health professional school or accredited residency clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed.

1. <u>What is Meant by the Active Clinical Practice of That Specialty</u>?

The term Active Clinical Practice of that Specialty was not legislatively defined in the statute. The term active is defined as "presently in operation or in use." **<u>The Merriam Webster Dictionary</u> (1994).** The term "clinical" is defined as "actual observation and treatment of patients as

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distinguished from data or facts obtain from other sources." **Taber's Cyclopedic Medical Dictionary (20th ed.)**. Thus, active clinical practice refers to a health professionals on going, actual personal and direct participation with the evaluation, diagnosis, and treatment of patients

As discussed above, the term "that specialty" refers to the primary specialty of the Defendant doctor. If the Defendant doctor has more than one primary specialty or is working in another recognized area of specialization , "that specialty" refers to the primary specialty that was actually involved in the alleged malpractice. **See Tate v Detroit Receiving Hospital, 249 Mich App 212; 642 NW2d 346 (2002); Nelson, supra.**.

2. Application to the Case At Bar

In the case at bar, Plaintiff's expert Dr. Markowitz spent a majority of his time in the active clinical practice of infectious disease. Dr. Markowitz testified that

that 98 % of his time is involved in the active practice of medicine. (**Appendix p. 33b**).

With respect to his practice he testified as follows:

Q. Would you explain for us what the nature of your practice there is in Keego Harbor?

A. Well, I have basically a two part kind of practice, I'm in the office half the time, and I'm at the hospital the other half of the time as a consultant. At my office I do internal medicine and infectious disease. In the hospital it's infectious disease related issues. (**Appendix pp 30b-31b**).

* * * *

Q. Okay. In your practice, in your office practice, do you take care of patients like Rosalie Ackley?

A. Yes, I do.

Q. Okay. Do you take care of patients that are in their 60s and 70s with high blood pressure.

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A. Yes, I do.

Q. With diabetes?

A. Yes.

Q. With Obesity?

A. Yes.

Q. With high cholesterol?

A. Sounds like all my patients, yeah.

Q. That have had TIA's

A. Yes.

Q. That have had strokes?

A. Yes.

Q. How frequently do you see patients like that?

A. Well, everyday. Except when I'm on vacation basically. (**Appendix pp 34b-35b**).

He further explained that infectious disease is a part of internal medicine.

Q. Now, the subspecialty training you did is what?

A. I did a fellowship in infectious diseases. Basically what that is is we have a primary interest in issues that relate to fevers, to bacterial infections, viral infections, meningitis, postoperative infections, wound infections, and how to use antibiotics.

Q. Isn't that kind of what an internist does anyway?

A. Well, internists have a broader area of expertise, but certainly a great deal of it relates to infection (**Appendix p 32b**)

He further testified that because Infectious disease, is a wholly contained sub-specialty of internal

medicine, 100% of his professional time was involved with internal medicine patients. (**Appendix p. 100b**).

Defendant's have argued that because Dr. Markowitz spent more than 50% of his professional time in his sub-specialty of infectious disease, he did not spend the majority of his professional time in the active clinical practice of internal medicine and thus, is not qualified to give expert testimony pursuant to **MCL 600.2169(1)(b); MSA 27A.2169(1)(b)** The Defendant's argument lacks merit.

Internal medicine is "[t]he medical specialty concerned with the overall health and well being of adults." **Taber's Cyclopedic Medical Dictionary (20th ed).** One of the recognized wholly contained sub-specialties of internal medicine is infectious disease. (**Appendix p 161b**). The first requirement in each sub-specialty recognized by the American Board of Internal Medicine, including infectious disease, is primary certification in Internal Medicine. (Appendix p. 168b). As previously indicated, the word "sub" is a prefix meaning subdivision or subordinate portion of larger group or class. **See Merrim Webster Dictionary (1994).** Thus, each sub-specialty is in fact still internal medicine.

Dr. Markowitz gave an excellent explanation of the relationship between his internal medicine and infectious disease practice. Dr. Markowitz testified that:

> I'm called in to evaluate the patients who have issues relating to infectious disease, but they don't stop being internal medicine issues. I guess my problem is that being qualified as in internist and then as an infectious disease person never takes away my internal medicine position. It is like my being a doctor means I'm no longer a man.
>
> * * *
>
> In infectious disease, all I do is come to the patient exactly as an internist but with a little better understanding of the

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> pathophysiology of infectious disease. I never stop being an internist. **(Appendix pp 46b, 97b)**.

While the Defendant seeks to paint Dr. Markowitz as an advocate, the undisputed fact remains that his explanation is in keeping with the infrastructure and requirements of the internal medicine specialty board as established by the American Medical Association.

A finding that the clinical practice of a sub-specialty is not the clinical practice of the primary speciality, in addition to be contrary to the express statutory language, would lead to absurd results. Many of the officers of the American Board of Internal Medicine have sub-specialty certifications. The then current chair Dr. David R. Dantzker is boarded in internal medicine with sub-specialty certification in critical care and pulmonology. The chair-elect Dr. Paul Ramsey is likewise certified in internal medicine with sub-specialty certificates in infectious disease. Because it is extremely likely that each of these physicians spend a good portion of their practice related to their areas of sub-specialization, **MCL 600.2169; MSA 27A.2169,** if interpreted as suggested by the Defendant-Appellant and as adopted by the trial court, the chairs of the American Board of Internal Medicine, the very board which sets the standards and prepares the test for certification for Internal Medicine specialists, would not qualify to give standard of care testimony against Dr. Kuligowski in this case.

Testimony regarding the amount of time an expert spends practicing within the area of his sub-specialty might be admissible or salient to the issue of how much weight to give his testimony. It, however, is not relevant to the issue of admissibility pursuant to the express language of **MCL 600.2169; MSA 27A.2169.**

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III. DR. MARKOWITZ WAS QUALIFIED TO GIVE STANDARD OF CARE TESTIMONY WHERE DR. MARKOWITZ WAS BOARD CERTIFIED IN INTERNAL MEDICINE AND TESTIFIED THAT HE ROUTINELY TREATED PATIENT'S SUCH A ROSALIE ACKLEY.

A. Standard of Review

Decisions regarding the qualifications of an expert witness, are reviewed for abuse of discretion. **Bahr v Harper Grace Hospital, 448 Mich 135, 141; 528 NW2d 170 (1995), App denied.** " An abuse of discretion exist where an unprejudiced person, considering the facts on which the trial court made it decision, would conclude that there is no justification for the ruling made." **Carpenter v Consumers Power, 230 Mich App 547, 562: 584 NW2d 375 (1998) vacated on other grounds, 615 NW2d 17 (2000).**

B. Analysis

Expert testimony generally is admitted pursuant to **MRE 702.** This evidentiary rule provides that "a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise." Defendant's assert that Dr. Markowitz was not qualified to testify as he could not opine as to the types of patients "an average internist sees day in or day out." The Defendant's assertion should be rejected.

First and foremost this issue was not preserved. The Defendant only challenged Dr. Markowitz's qualifications pursuant to **MCL 600.2169; MSA 27A.2169 (Appellant's Appendix, p.76a).** Objections raised on one ground are insufficient to preserve an appellate challenge on another ground. **People v Michael, 181 Mich App 236; 448 NW2d 786 (1990).** The issue, therefore, was not raised before or decided by the trial court nor by the Court of Appeals. Issues not or raised for the first time are reviewed only if the failure to review would result in a miscarriage of

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justice. **Petrus v Dickson Co. Comm'rs, 184 Mich App 282, lv den, stay den 435 Mich 879 (1990).** Failure to review this issue will not result in a miscarriage of justice as the matter could simply be remanded to the Trial Court for consideration as was done by the Court of Appeals. **(Appendix p. 3b, FN 2).**

Second, in order to provide standard of care testimony an expert must establish that he is familiar with the applicable standard of care. The Standard of Care in the case at bar is that which an internist of ordinary learning, judgment, or skill in this or a similar community would do under the same or similar circumstances. **M Civ JI 30.01.** The standard of care does not require that the expert know the type of patients the average internist sees daily.

Third, Dr. Markowitz provided sufficient testimony to establish his familiarity with the standard of care. Dr. Markowitz testified that he was an internist practicing in Metropolitan Detroit. He stated the his practice was in Oakland County.(**Appendix p.30b, lns 18-20**). He testified that he attended medical school at Wayne State University, he did a residency in internal medicine as well as a fellowship in his sub-speciality, infectious disease. (**Appendix pp 32b-33b.**). He testified that he is licensed as a physician in the state of Michigan, and he is board certified in Internal Medicine. (**Appendix pp. 31b, 34b**) Dr. Markowitz testified that 98 % of his time is involved in the active practice of medicine. (**Appendix p. 33b**).

With respect to his practice he testified as follows:

Q. Would you explain for us what the nature of your practice there is in Keego Harbor?

A. Well, I have basically a two part kind of practice, I'm in the office half the time, and I'm at the hospital the other half of the time as a consultant. At my office I do internal medicine and infectious disease. In the hospital it's infectious disease related issues. (**Appendix pp 30b-31b**).

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* * * *

Q. Okay. In your practice, in your office practice, do you take care of patients like Rosalie Ackley?

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Q. Okay. Do you take care of patients that are in their 60s and 70s with high blood pressure.

A. Yes, I do.

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Q. That have had strokes?

A. Yes.

Q. How frequently do you see patients like that?

A. Well, everyday. Except when I'm on vacation basically. (**Appendix pp 34b-35b**).

He further testified that because Infectious disease, is a wholly contained sub-specialty of internal medicine, 100% of his professional time was involved with internal medicine patients. (**Appendix p. 100b**).

It is clear from Dr. Markowitz's testimony that in light of his education, training, and

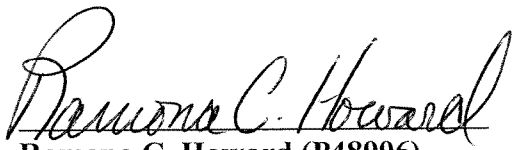
experience, he is well qualified to testify regarding what an internist of ordinary learning, judgment, or training would have done in the treatment of Mrs. Ackley. Any in ability to testify as to the types of patients seen by an average internist does not disqualify Dr. Markowitz from testifying as to the standard of care of an internist.

RELIEF REQUESTED

For the foregoing reasons, Plaintiff-Appellee, Shirley Hamilton as Personal Representative of the Estate of Rosalie Ackley, respectfully pray that this Honorable Court affirm the Court of Appeals' decision Reversing the trial court's orders striking Plaintiff's expert and dismissing Plaintiff's claim.

Respectfully submitted,

McKeen & Associates, P.C.

BY: 

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STATE OF MICHIGAN

IN THE SUPREME COURT

APPEAL FROM THE MICHIGAN COURT OF APPEALS
O'CONNELL, P.C., AND JANSEN AND MURRAY, JJ.

SHIRLEY HAMILTON, as Personal Representative of the Estate of **ROSALIE ACKLEY**, Deceased

Plaintiff-Appellant,

and

BLUE CROSS/BLUE SHIELD OF MICHIGAN,

Intervening Plaintiff

vs

MARK F. KULIGOWSKI, D.O.

Defendant-Appellee

Supreme Court No.: 126275

Court of Appeals No.: 244126

Saginaw County Circuit Court No.: 00-033440-NH

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AFFIDAVIT OF SERVICE

STATE OF MICHIGAN)
) SS.
COUNTY OF WAYNE)

Adrienne V. Hughes, being first duly sworn, deposes and states that she is employed with the firm of McKEEN & ASSOCIATES, P.C., and that on the 10 October 2005 , she did serve a copy of *Plaintiff-Appellee's Brief on Appeal, Appellee's Index,* and *Affidavit of Service* upon all Counsel of record at their respective business addresses as set forth in the caption of these pleadings, by placing said documents in properly addressed envelopes with first class postage affixed and depositing same in a U.S. Mail receptacle located in the City of Detroit.

I declare under penalty of perjury that the statements above are true to the best of my information, knowledge and belief.

Further, affiant saith not.

Adrienne V. Hughes

DATED: **October 10, 2005**

Subscribed and sworn to before me this *10th* day of *October*, 2005

SHEA BROUSTER

NOTARY PUBLIC in and for the
County of *Wayne*, State of *Michigan*,
Acting in *Wayne*, County
My Commission Expires: *January 31, 2006*

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